PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, January 27, 2004, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Ms. Christine Ferguson, (Chair), Ms. Phyllis Cudmore, Ms. Maureen Pompeo, Mr. Albert Sherman, Ms. Janet Slemenda, Dr. Thomas Sterne, M.D., Mr. Gaylord Thayer, Jr., and Dr. Martin Williams. Mr. Manthala George Jr. absent. Also in attendance was Attorney Donna Levin, General Counsel.

****

Chair Ferguson announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

****

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. J.K. West, Ph.D., Chief Demographer and Epidemiologist, Center for Health Information, Statistics, Research and Evaluation; Ms. Sally Fogerty, Assistant Commissioner, Bureau of Family and Community Health; Dr. Susan Gershman, Director, Massachusetts Cancer Registry; Mr. Robert Walker, Director, Radiation Control Program; Ms. Suzanne Condon, Assistant Commissioner, Center for Environmental Health; Dr. Alfred DeMaria, Assistant Commissioner, Bureau of Communicable Disease Control; Ms. Joyce James, Director, Determination of Need Program; and Deputy General Counsels Sondra Korman, Edmund Sullivan, and James Ballin.

PERSONNEL ACTIONS:

In a letter dated January 8, 2004, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointment and reappointments to the provisional and medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointment and reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning January 1, 2004 to January 1, 2006:

REAPPOINTMENT:	**MASS. LICENSE NO.:**	**STATUS:**
Roseanne Schipani, M.D.	74187	Active

APPOINTMENT:

Edith Kaplan, PhD	799	Provisional Allied Psychology

In a letter dated January 12, 2004, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Westfield, recommended approval of the initial appointment and reappointment to the medical staff of Lemuel Shattuck Hospital. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under that authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointments to the medical staff of Lemuel Shattuck Hospital be approved as follows:

APPOINTMENT:	**MASS. LICENSE NO.:**	**STATUS:**
James Pasternack, M.D.	77918	Consultant/Ophthalmology

REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS:**
Farshid Fararooy, M.D.	74864	Active/Internal Medicine
Carl Kramer, M.D.	51314	Active/Neurology
Rafeeque Bhadelia, M.D.	78973	Consultant/Radiology
David Ricklan, M.D.	81423	Pathology
Amy Lisser, M.D.	60303	Active/Psychiatry
Barbara Maxwell, M.D.	34716	Active/Psychiatry

Allied Health Professional Reappointments:

Mary Connolly, PA – Department of Surgery/Orthopedic #36
Rocco LoRicco, PA – Department of Surgery #551
Christopher Manning, NP – Department of Medicine #205286

STAFF PRESENTATION:

"MASSACHUSETTS BIRTHS 2002", BY J.K. WEST, PH.D., CHIEF DEMOGRAPHER AND EPIDEMIOLOGIST, CENTER FOR HEALTH INFORMATION, STATISTICS, RESEARCH AND EVALUATION:

Dr. J.K. West, Ph.D., Chief Demographer and Epidemiologist, Center for Health Information, Statistics, Research and Evaluation, presented the report, "Massachusetts Births 2002". Among the highlights:

- The teen birth rate continues its steady decline of the last twelve years. The Massachusetts teen birth rate has decreased steadily from 35.4 births per 1,000 women ages 15-19 in 1990 to 22.6 in 2002; the lowest teen birth rate in the last 3 decades.

- The infant mortality rate (IMR) in 2002 was 4.9 infant deaths per 1,000 live births, compared with 5.0 in 2001. The year 2002 had the second lowest number of infant deaths in Massachusetts history.

- The Cesarean section delivery rate continues to increase in Massachusetts as well as throughout the United States. In 2002, 28.2% of all births to Massachusetts residents were delivered by c-section, the highest rate ever reported in the state. This is a 10% increase from the 2001 c-section rate. Since 1997; c-section rates have increased by an average of 7% per year.

- The percentage of women smoking during pregnancy decreased from 9.1% in 2001 to 7.9% in 2002, continuing its steady decline from the last decade. The rate of smoking during pregnancy has decreased 59% since 1990 (19.3%).

- The percentage of low birth weight infants (less than 2,500 grams or 5.5 pounds) increased to 7.5% in 2002, the highest since at least 1980. Since 1990, the percentage of low birth weight infants has increased by 29%, from 5.8% in 1990 to 7.5% in 2002. The increase in low birth weight infants can be linked directly to the increase in multiple births and the aging of the population giving birth.

- The percentage of preterm infants (delivered before the 37^{th} week of gestation) increased 6% from 8.0 in 2001 to 8.5% in 2002.

- The twelve-year trend of increasing numbers of multiple births continues. The percentage of multiple births increased from 4.4% of births in 2001 to 4.9% in 2002. The percentage of multiple births in Massachusetts has increased 89% since 1990 (2.6%).

- The age of birth mothers in Massachusetts continues to increase. In 1980, 1 out of 4 Massachusetts mothers were ages 30 and over, now more than 1 in 2 (57%).

- In Massachusetts, the average age at first birth was 28.0 years in 2002 compared with 25.1 years for the United States, which was an all time high.

- Despite a very small percent (less than 1%) decrease in overall births from 2001, certain groups have experienced large increases in the numbers of births. Five groups have increased more than 10%: Asian Indians, Brazilians, Chinese, Africans, and Vietnamese.

MISCELLANEOUS:

REQUEST FOR ADOPTION OF THE FINAL DECISION IN THE MATTER OF DEPARTMENT OF PUBLIC HEALTH, OFFICE OF EMERGENCY MEDICAL SERVICES V. JAMES W. NOLAN, JR.:

Deputy General Counsel Sondra M. Korman, Massachusetts Department of Public Health, said in part, "The Department of Public Health initiated the administrative action to temporarily revoke the certification of James W. Nolan, Jr. as an emergency medical technician for thirty days and to require that Mr. Nolan complete a remedial training program. On December 1, 2003, the Administrative Magistrate of the Division of Administrative Law Appeals issued a Recommended Decision, which found that Mr. Nolan violated the Department's regulations when he omitted material facts, both in writing and in verbal discussions with hospital staff, regarding a patient's pre-hospital emergency treatment. The Department has prepared a Recommended Final Decision which contains certain modifications to the Magistrate's Recommended Decision. Mr. Nolan has not objected to the Magistrate's decision or the Recommended Final Decision. In this case, the Department through the Office of Emergency Medical Services, conducted an investigation of a May 15, 2002 emergency response by EMT Paramedics James Nolan and Louis Nizzari for a patient in cardiac arrest. During the emergency response, Nolan's partner set up the cardiac monitor and applied the paddles to the patient's chest to obtain a reading of the heart rhythm. The partner determined from the electrocardiograph reading that the patient was in ventricular fibrillation and delivered three escalating defibrillations. After the third shock, the monitor leads were placed on the patient and the electrocardiograph reading showed that the patient was in asystole. The patient was transported to the hospital and Mr. Nolan gave a verbal report to the emergency room physician and staff regarding the patient's pre-hospital emergency care. He then retrieved the code summary from the cardiac monitor and determined that it did not show VF at the time the patient was defibrillated. Rather, the code summary showed artifact – a distortion that does not reflect true cardiac function. Nolan's partner had inaccurately interpreted the electrocardiograph reading as VF, when in actuality, he was reading only artifact. In addition, the code summary reflected that the monitor had been set in an incorrect mode (Lead II rather than manual paddles). Mr. Nolan did not relay this information to the emergency room staff. Additionally, Mr. Nolan prepared the Patient Care Report and omitted information regarding the artifact reading."

Deputy General Counsel Korman continued, "...The Department found that the partner failed to exercise reasonable care, judgement, and ability in violation of the governing

regulations. Because he had no prior enforcement history with OEMS and the ambulance service had initiated a remedial training program, OEMS issued a Letter of Reprimand to the partner. Additionally, the partner completed a physician-directed remediation in assessment of cardiac rhythms. With respect to Mr. Nolan, the Department found that he violated the regulations when he documented that the patient was in VF, knowing that the cardiac summary did not support this fact. In light of the investigation findings and Mr. Nolan's prior disciplinary history with the Department, the Department recommended that Mr. Nolan's certification be temporarily revoked and that a remedial training program be required. It is recommended that, consistent with the Department's objections, the Commissioner and Public Health Council affirm and adopt the Department's Recommended Final Decision as the final decision of the Department in this matter.

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve the Request for Adoption of the Department's Final Decision in the matter of the Department of Public Health, Office of Emergency Medical Services v. James W. Nolan, Jr.** A copy is attached to and made a part of this record as **Exhibit Number .**

PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING ON AMENDMENTS TO 105 CMR 301.000: CANCER REGISTRY:

Dr. Susan Gershman, Director, Massachusetts Cancer Registry, began, "In 1980, the Legislature authorized the Department of Public Health to establish the Massachusetts Cancer Registry to record cases of malignant disease in residents of the Commonwealth. The legislation, codified as Massachusetts General Laws, Chapter 111, Section IIIB, specifically authorized the Department to collect such information relating to malignant diseases as it deems necessary and appropriate in order to conduct epidemiologic surveys of cancer and to apply appropriate preventative and control measures. Pursuant to this authority, the Department in 1981 promulgated 105 CMR 301.000: Cancer Registry, which established the Massachusetts Cancer Registry (MCR). The Massachusetts Cancer Registry began collecting malignant disease data in 1982. Under these regulations, as amended in 1995, any health care provider diagnosing a case of cancer in Massachusetts is required to report information on such malignant disease to the cancer registry. Confidential cancer registry; data are used by Department staff for reporting on cancer incidence in Massachusetts, for cancer research, and for responding for aggregated, de-identified data from the legislature, the media, and the public relating to cancer incidence. The MCR also permits access to confidential cancer data to qualified researchers outside the Department for purposes of conducting public health research, subject to strict confidentiality requirements. Collection of this information is critical to cancer researchers who conduct studies intended to reduce morbidity and mortality in Massachusetts."

Dr. Gershman continued, "The MCR participates in the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries and receives approximately 75% of its funding from the CDC. In 2002, Congress passed the Benign Brain Tumor Cancer Registries Amendment Act which requires states that participate in the CDC National Program of Cancer Registries to begin reporting of benign brain-related tumors to the state cancer registry. CDC is requiring state cancer registries to have reporting authority for benign brain-related tumors in 2004. The federal legislation specifically defines benign brain-related tumors which include tumors in the brain, central nervous system, and spinal cord. Since the original enabling legislation for the MCR was limited only to the collection of information related to malignant disease which does not include benign brain-related tumors, the Department believed it was necessary to amend this statute to expand the collection authority to include benign brain-related diseases in order to comply with this federal requirement and maintain federal funding. In addition to complying with this new federal requirement, the MCR believes that collection of information on benign brain-related tumors is important due to the fact that the sensitive location of these tumors can have life-threatening consequences. Further research is warranted on these potentially fatal tumors."

Dr. Gershman concluded, "In response to this new federal requirement, the Legislature included language in the latest supplemental budget which amends MGL c. 111, S 111B, to allow the MCR to also collect information related to benign brain-related tumors. Since reporting of benign-brain related tumors is not covered under existing MCR regulations, these proposed amendments are intended to include reporting of benign-brain-related tumors. The minimal impact on mandated reporters since there is already a process in place for malignant disease reporting to the Department and since many providers have already been providing data on benign brain-related tumors. The number of benign brain-related tumors that are expected to be reported to the Department represents less than 1% of the total number of annual cancer cases reported to the Department. While many providers have been voluntarily providing benign brain-related tumor information, this voluntary collection of tumor data has been declining since the implementation of the federal privacy rules issued pursuant to the Health Insurance Portability and Accountability Act. (HIPAA). In addition to new reporting requirements for benign brain-related tumors, these amendments also contain some language changes to clarify what information is required to be reported and who is required to report."

INFORMATIONAL ONLY – NO VOTE

INFORMATIONAL BRIEFING ON NEW REGULATIONS TO 105 CMR 124.000: PROVISION OF THYROID BLOCKING AGENTS:

Mr. Robert Walker, Director, Radiation Control Program, said, "The term "thyroid blocking agents" refers to drugs or chemicals that can be ingested and that will prevent the absorption by the thyroid gland of radioactive isotopes of iodine that may be released to the environment during an accident at a nuclear power station. To date, the only thyroid blocking agent approved by the US Food and Drug Administration is potassium iodide, known more commonly by its chemical symbol 'KI'. In late 2001, the federal

government, through the US Nuclear Regulatory Commission, offered cost-free KI tablets to any state wishing to obtain them. This KI was intended for residents, workers, and school children in established Emergency Planning Zones within 10 miles of nuclear power reactors. The federal program supplied a total of 260 milligrams of KI (two 130 milligram tablets) for every eligible person. In January 2002, the Commonwealth requested these tablets, and has been distributing them to eligible individuals, employers, public and private schools, daycare facilities and camps that request them. Massachusetts General Laws Chapter 111, Section 5K, was amended by the Legislature in December 2002 to require the Department of Public Health to provide thyroid blocking agents approved by the FDA to the cities and towns situated within the established ten-mile radius EPZs surrounding a nuclear power station. Since K1 has already been made available directly to eligible individuals and organizations within the EPZs through the federally-supplied program, the Department considers this new requirement to have already been met at this time. However, when the shelf life of the federally-supplied K1 expires in 2007, this legislative amendment would be invoked to obtain and supply replacement K1 to the EPZ cities and towns. The statute further requires the Department to provide thyroid blocking agents approved by the FDA to the cities and towns situated on Cape Cod, Martha's Vineyard, Nantucket and Cape Ann which request such thyroid blocking agents."

Mr. Walker continued, "The Statute authorized the Department to assess the costs of this program to the owners of any nuclear power station in the Commonwealth, and to electric companies in the Commonwealth which own, in whole or in part, or purchase power from the Seabrook nuclear power plant in New Hampshire. The revenue from these assessments was directed by the statute into the Department's retained revenue account that funds nuclear power plant environmental monitoring activities. However, this retained revenue account contains an expenditure cap for radiation monitoring activities, and any funds placed into this account in excess of the cap are directed to the Department's retained revenue account which has been established for other purposes. Because this would mean that revenue raised for supplying thyroid blocking agents would not be available to purchase them, the Department requested the legislature to undertake a technical amendment to the statute so the funds would be directed to the Department's Radiation Control Trust Account, one that could be accessed to fund the purchase of K1. This technical amendment was made by the legislature on July 1, 2003, but unfortunately it did not correct the problem entirely. The appropriate account is now referenced for the funding of K1 that is purchased for the Emergency Planning Zones, but the incorrect account is still referenced for K1 that is purchased for Cape Cod, Martha's Vineyard, Nantucket and Cape Ann. Department staff anticipate that the problem will be rectified in the near future through an additional technical amendment to the statute. In order to comply with the statutory requirement to promulgate regulations governing the purchase and distribution of thyroid blocking agents, the Department is proposing new regulations entitled "Provision of Thyroid Blocking Agents."

PROPOSED REGULATIONS:

Definitions: The proposed regulations include definitions for administrative and geographical purposes, such as the definition of thyroid blocking agents, the geographical areas envisioned by the statute, and the identification of the sources of revenue.

Funding: The proposed regulations permit the Department to assess the costs of the program to the owners of any nuclear power station in the Commonwealth, and to electric Companies in the Commonwealth which own, in whole or in part, or purchase power from the Seabrook nuclear power plant in New Hampshire. The method of prorating the amount of the assessment to each entity is described.

Purchase of K1: K1 is approved by the FDA in tablets of 65 milligram or 130 milligram dosages. It is proposed to supply a total of 260 milligrams of K1 per person under this program, similar to the amount supplied per capita under the existing K1 distribution program. This will be accomplished in the most cost-effective manner by purchasing either 65 milligram tablets or 130 milligram tablets, whichever are the least expensive.

Request by City or Town: The proposed regulation requires each city or town desiring to participate in this program to submit a written request to the Department, indicating that its governing body has voted to accept K1. The term "governing body" is found in the statute, and is not defined either there or in this proposed regulation. The individual municipalities will determine for themselves who comprises their "governing body".

PROMULGATION OF REGULATIONS:

The Department will solicit review and comments on these proposed regulations by the affected public, and will conduct a public hearing on the proposed regulations in March. Following this hearing, the Department will review the comments received and make any appropriate revisions to the proposed regulations."

NO VOTE – INFORMATIONAL ONLY

REGULATIONS:

REQUEST FOR PROMULGATION OF AMENDMENT TO 105 CMR 430.000: MINIMUM SANITATION AND SAFETY FOR RECREATIONAL CAMPS FOR CHILDREN STATE SANITARY CODE, CHAPTER IV:

Attorney Edmund Sullivan, Deputy General Counsel, Department of Public Health, presented the regulations to Council. Attorney Sullivan said, "The Department of Public Health is mandated by G.L. c.111, s127A to regulate recreational camps for children. The regulations at 105 CMR 430.000 were most recently amended in June of 2003. At that time, the Department's final marked-up galley showing all revisions to be made in the regulations inadvertently failed to indicate that section 105 CMR 430.204(B) remained in the amended regulations. As a result, the Secretary of State's Regulation's

Division revised the regulations deleting the existing 105 CMR 430.204(B), a section that requires camp operators to determine a camper's swimming ability at the first swim session. The Division of Community Sanitation (DCS) now seeks to redress this error by returning the swimming test provision to 105 CMR 430.000. Notice of public hearing and a request for comments were published in the Boston Herald and the Springfield Union. The hearing was held on December 29, 2003 at the State Laboratory Institute. No one attended the hearing and no written comment was received by DCS on this matter."

After consideration, upon motion made and duly seconded, it was voted, unanimously to **approve the Request for Promulgation of Amendment to 105 CMR 430.000: Minimum Sanitation and Safety Standards for Recreational Camps for Children, State Sanitary Code, Chapter IV;** that a copy of the regulations be forwarded to the Secretary of the Commonwealth and that a copy of the regulations be attached to and mad a part of this record as **Exhibit Number .**

REQUEST FOR FINAL ADOPTION OF AMENDMENTS TO 105 CMR 300.000 – REPORTABLE DISEASES, SURVEILLANCE, AND ISOLATION AND QUARANTINE REQUIREMENTS:

Ms. Suzanne Condon, Assistant Commissioner, Bureau of Environmental Health Assessment, introduced the regulations. Ms. Condon began, "The purpose of this memorandum is to summarize the development of the revisions of 105 CMR 300.000: Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements, testimony submitted, and the response of the Massachusetts Department of Public Health staff. These regulations will authorize the Department to conduct surveillance (without requiring reporting) for certain diseases that are possibly linked to environmental exposures. Massachusetts is one of seven states to be asked by the U.S. Centers for Disease Control and Prevention ("CDC") to develop and implement surveillance systems to track the occurrence of environmentally related diseases. In addition, the regulations have been updated to add the emerging diseases Severe Acute Respiratory Syndrome (SARS) and Monkeypox to the list of reportable diseases and incorporate the latest federal recommendations for isolation and quarantine. On March 20, 2003, pursuant to 105 CMR 300.150, the Commissioner temporarily added (for a 12-month period) SARS to the list of reportable diseases. Revision of the regulations is required to make this designation permanent.

DESCRIPTION OF THE PROPOSED REVISIONS TO THE REGULATIONS

A. Background

M.G.L. C.111, SS 1, 3, 5, 6, 7, 94C, 109, 110, 110B, 111 and 112 establish the responsibilities of the local boards of health and the Department with respect to the reporting and control of communicable diseases. M.G.L. c.111D, S 6 references clinical laboratories in reporting to the Department.

B. Summary of Revisions:

Primary revisions to the regulations may be summarized as follows:

1. To accurately reflect and provide further clarity on the scope of the regulations, the term "surveillance" has been included in the title of the regulations and subsequent text. The text now reads: Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements.
2. 300.020: Definitions. The term "food handler" was defined.

3. 300.100: Diseases Reportable to Local Boards of Health. Monkeypox and infection with any other orthopox virus in humans and Severe Acute Respiratory Syndrome (SARS) and infection with the SARS-associated coronavirus were added to the list of reportable diseases. As noted above, SARS was declared immediately reportable pursuant to 300.150 in March 2003 and must be formally incorporated into the regulations within 12 months of that date in order to remain reportable.

4. 300.150: Declaring a Disease or Condition Dangerous to the Public Health Immediately Reportable, Under Surveillance and/or Subject to Isolation and Quarantine: Temporary Reporting, Surveillance and/or Isolation and Quarantine. This section was modified to allow the Commissioner, in addition to requiring the immediate reporting of newly recognized or identified diseases, to authorize the surveillance and/or establish isolation and quarantine requirements for such diseases. Any such declarations by the Commissioner shall be authorized for a time period not to exceed 12 months, after which new regulations must be promulgated.

5. 300.170: Laboratory Findings Indicative of Infectious Disease Reportable Directly to the Department by Laboratories. Monkeypox virus and evidence of infection with any other orrthopox virus in humans, and SARS-associated coronovirus were formally added to the list of organisms laboratories are required to report.

6. 300.190: Surveillance and Control of Diseases Dangerous to the Public Health. The term "monitoring" was added to clarify the scope of the Department's surveillance and control activities.

7. 300.191: Access to Medical Records and Information. The term "monitor" was added to clarify the purposes for which the Department may seek access to medical records and other information concerning diseases dangerous to the public health.

8. 300.192: Surveillance of Diseases Possibly Linked to Environmental Exposures. This section was added to authorize the Department to collect and/or prepare data on individuals evaluated or diagnosed with specifically listed diseases possible linked to environmental exposures. The specific diseases are: Amyotrophic Lateral Sclerosis (ALS), Aplastic Anemia, Asthma, Autism Spectrum Disorder

(ASD), Multiple Sclerosis (MS), Myelodysplatic Syndrome (MDS), Scleroderma and Systemic Lupus Erythematosus.

9. 300.200: Isolation and Quarantine Requirements.

SUMMARY OF TESTIMONY:

The Department held a public hearing on the proposed amendments to the Reportable Diseases , Surveillance, and Isolation and Quarantine Requirements on January 8, 2004 in Canton, MA at the Metrowest Regional Office. No oral testimony was presented. The Department received a total of six pieces of written testimony, all strongly in support of the revised regulations. No testimony or comments were received in opposition to the regulations. The following individuals submitted written testimony in support of the revisions:

John A. Hart, Jr., Massachusetts State Senator, First Suffolk District
Joseph H. Korn, MD, Boston University Medical Center
Lisa A. Borges, Executive Director, The Doug Flutie, Jr. Foundation for Autism, Inc.
Dennis C. Russo, PhD, ABPP, Chief Clinical Officer, The May Institute
David Wilmot
Timothy McAlindon, MD, MPH, Chief, Division of Rheumatology, Associate Professor of Medicine, Tufts New England Medical Center

No changes have been made in the proposed amendments.

Adoption of the proposed regulations will allow the Department to undertake surveillance of diseases possibly linked to environmental exposures as requested by the CDC. It will also allow the Department to continue to require the reporting of SARS; establish reporting requirements for another emerging disease, Monkeypox; and incorporate the most recent federal recommendations for isolation and quarantine. We request that the Public Health Council approve promulgation of the amended regulations."

After consideration, upon motion made and duly seconded, it was voted unanimously that **the Request for Final Adoption of Amendments to 105 CMR 300.000 – Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements be approved**; and that a copy of the regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the regulations be attached to and made a part of this record as **Exhibit Number** .

REQUEST FOR FINAL PROMULGATION OF PROPOSED AMENDMENT TO DETERMINATION OF NEED REGULATIONS 105 CMR 100.000 GOVERNING APPLICATIONS FILING DAY FOR CONVALESCENT, NURSING AND REST HOME RENOVATION AND REPLACEMENT PROJECTS:

Ms. Joyce James, Director, Determination of Need Program, said, "The purpose of this memorandum is to request the Public Health Council's approval for final promulgation of the amendment to the Determination of Need Regulations 105 CMR 100.302, governing Filing Days for Applications and Amendments. This amendment changes the filing day of Determination of Need applications for convalescent, nursing and rest home projects, subject to licensure by the Department pursuant to M.G.L. c. 111 S 71, from the first business day of May 2003 to the first business day of May 2006. The Public Health Council was briefed on the proposed amendment on September 23, 2003. A public hearing on the proposed amendment was held on November 5, 2003. Three people attended the meeting and one person testified, a representative of Massachusetts Extended Care Federation. Written comments were also received from the Federation. The Federation recommends limiting the moratorium on construction of new nursing home beds to two instead of four years by extending the filing day for applications from May 1, 2003 to May 1, 2005 instead of to May 1, 2007 as the Department had initially proposed by the amendment. The Federation also recommends addition of a regulatory provision to allow filing of DoN applications for construction of new nursing homes due to facilities' closures in one geographic area. The Federation argues that the Department's bed need projections based on statewide, age-specific utilization rates applied to age-specific 2005 and 2010 population projections might mask the shortage of beds in certain cities and towns. Thus, it contends, it is important that the Department determine bed need projections at the HSA (Health Service Area) and sub-area levels prior to extending the filing day. The Federation further contends that the Department's bed need projects assume that the existing supply of beds will remain constant from September 2003 through May 2010, when over 6,000 beds have been closed since 1999. Additionally, the Federation argues that the inclusion of 1,325 BANYLS (beds approved but not yet licensed) is inappropriate because it appears unlikely that those beds will be built, given the state's inadequate Medicaid capital reimbursement rates."

Ms. James continued, "Staff notes that the proposed amendment to extend the filing day for applications proposing new construction of nursing home beds to the first business day of May 2007 was based on a need analysis applied 2002 statewide age-specific utilization rates, adjusted for long-term declines in nursing home utilization rates, to MISER 2005 statewide age-specific population projections, which resulted respectively in statewide surpluses of 6,899 and 7,627 nursing home beds. It was also determined that if utilization rates were held constant at 2002 levels, the surplus in 2005 would be reduced to 993 beds in 2005 with an unmet need of 1,701 beds in 2010. Department staff agrees that statewide utilization rates have a tendency to either overestimate or underestimate the use rates for specific cities and towns. Staff notes that the 6,000 closed beds cited by the Federation appear to include both closed beds and beds out of service. Nevertheless, Staff believes that it might be prudent to reduce the moratorium period to ensure timely responses to any acute shortages of nursing facility beds. Thus, staff recommends extending the next filing day to the first business day of May, beginning 2006. During the interim, staff will assess need for new beds on a regional level by HSA based on the MISER 2010 population projections for cities and towns, which became available December 10, 2003. Staff notes that DoN regulations allow for the filing of an

emergency application if there is a critical bed shortage. Staff also notes that the Federation's argument regarding BANYLS not being built because of financial reasons would also apply to new beds approved in the next few years. After careful consideration of these comments, staff recommends that the proposed amendment extend the filing day for convalescent nursing and rest homes' applications, subject to licensure by the Department pursuant to M.G.L. c. 111 s 71, from the first business day of May 2003 to the first business day of May 2006. The Department asks that this amendment be approved for final promulgation as presented today."

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve the Request for Final Promulgation of Proposed Amendment to Determination of Nee d Regulations 105 CMR 100.000 Governing Applications Filing Day for Convalescent, Nursing and Rest Home Projects Subject to Licensure by the Department Pursuant to M.G.L. c.111 S 71**; that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number** .

REQUEST FOR FINAL PROMULGATION OF PROPOSED AMENDMENT TO DETERMINATION OF NEED REGULATIONS 105 CMR 100.000 GOVERNING APPLICATIONS FILING DAY FOR CONVALESCENT, NURSING AND REST HOME RENOVATION AND REPLACEMENT PROJECTS:

Ms. Joyce James, Director, Determination of Need Program said, "The purpose of this memorandum is to request the Public Health Council's approval for final promulgation of the amendment to the Determination of Need Regulations 105 CMR 100.302, governing Filing Days for Applications and Amendments. This amendment changes the filing day of Determination of Need applications for alteration of, making of major repairs to, remodeling of, renovation of, or replacement of convalescent, nursing and rest home projects from the first business day of January, beginning in January 1998, to any business day. The Public Health Council was briefed on the proposed amendment on October 28, 2003. A public hearing on the proposed amendment was held on December 15, 2003. No one from the public attended the hearing. Written comments were received from the Massachusetts Extended Care Federation, Mount Pleasant Home, and Massachusetts Aging Services Association, Inc. Mount Pleasant Home supports the proposed amendment, because of the flexibility it will provide in planning for the improvement of its facility and quality of care for its residents. The Home also states that filing an application on any business day rather than on the first business day of January will result in an application that is more efficient to review because of more complete information about design, financing and local approvals for the project. Massachusetts Aging Services Association, Inc. also supports the proposed amendment. The Association states that the planning process for submission of applications for physical plant improvement may take a longer time than anticipated and in order to meet the first business day of January deadline, applications may be filed prematurely resulting late n amendments to the approved project. The Massachusetts Extended Care Federation states that it does not oppose the proposed amendment but does not believe that it will

materially improve the physical plant capacity. The Federation states that of the more than 100 renovations and replacement projects approved by the Department since 1993 a mere handful have been able to replace their facilities due to inadequate Medicaid capital reimbursement . In light of the significant number of approved projects that have not proceeded with renovation and replacement of their facilities, the Federation recommends that the Department conduct an examination of physical plant capacity to ensure that facilities are adequately maintained. The Federation states that this examination should review the Medicaid capital payment method.
Staff appreciates the support of the proposed amendment by the Home and the Association staff also recognizes the financial hardships experienced by facilities in implementing their DoN approved projects. However, Medicaid capital reimbursement policies are governed by different legislation and regulations and are therefore outside the scope of the DoN Program. After careful consideration of these comments, Staff continues to recommend the proposed amendment to change the filing day for nursing and rest homes' applications for renovation and replacement projects. The Department asks that this amendment be approved for final promulgation."

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve the Request for Final Promulgation of Proposed Amendment to Determination of Need Regulations 105 CMR 100.000 Governing Applications Filing Day for Convalescent, Nursing and Rest Home Renovation and Replacement Projects**; that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth: and that a copy of the approved regulations be attached to and made a part of this record **as Exhibit Number** .

The meeting adjourned at 11:20 a.m.

_____
Christine Ferguson, Chair
Public Health Council

LMH/SB